PASSER RESTORATIVE THERAPIES

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ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been offered a copy of PASSER RESTORATIVE THERAPIES "Notice of Privacy Practices "I have therefore been advised of how health information about me may be used and disclosed by PASSER RESTORATIVE THERAPIES. Finally, by signing below, I consent to the disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of PASSER RESTORATIVE THERAPIES

With my consent, PASSER RESTORATIVE THERAPIES may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care options (TPO).

With my consent, PASSER RESTORATIVE THERAPIES may initiate a complaint to the Insurance Commissioner for any reason on my behalf.

With my consent, PASSER RESTORATIVE THERAPIES may deposit checks received on my behalf when made to the policy holder and received by his office.

With my consent, PASSER RESTORATIVE THERAPIES, may call my home or other designated location and leave messages on a voice mail or discuss in reference to any items that assist the practice. In carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, PASSER RESTORATIVE THERAPIES, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Patients Name: _____

Signature of Patient: _____

Signature of Patient's Representative: _____

Relationship of Patient's Representative: _____

Date: _____

*A photo copy of this assignment shall be considered as effective and as valid as the original